



# LOS ANGELES COUNTY COMMISSION ON HIV

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## STANDARDS OF CARE COMMITTEE MEETING MINUTES

March 3, 2011

Approved  
4/7/2011

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	HIV EPI AND OAPP STAFF	COMM STAFF/CONSULTANTS
Angélica Palmeros, Co-Chair	Anthony Braswell	Aaron Fox	None	Jane Nachazel
Fariba Younai, Co-Chair	Mark Davis	Miki Jackson		Glenda Pinney
Louis Guitron	David Giugni	Jason Wise		Craig Vincent-Jones
Jenny O'Malley	Terry Goddard			
Carlos Vega-Matos	Jeff Goodman			
Jocelyn Woodard				

### CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Standards of Care Committee Agenda, 3/3/2011
- 2) **Minutes:** Standards of Care (SOC) Committee Meeting Minutes, 9/2/2010
- 3) **Minutes:** Standards of Care (SOC) Committee Meeting Minutes, 11/4/2010
- 4) **Minutes:** Standards of Care (SOC) Committee Meeting Minutes, 12/2/2010
- 5) **Minutes:** Standards of Care (SOC) Committee Meeting Minutes, 1/6/2011
- 6) **Table:** Medical Care Coordination: OAPP Model ("Decisions to Date") vs. Commission on HIV Standards of Care, *updated 1/5/2011*
- 7) **Standards of Care:** Medical Care Coordination Services Standards of Care, 10/9/2008
- 8) **Standards of Care:** Benefits Specialty Services Standards of Care, 5/14/2009

1. **CALL TO ORDER:** Dr. Younai called the meeting to order at 10:15 am.

2. **APPROVAL OF AGENDA:**

**MOTION #1:** Approve the Agenda Order with Item 9 moved ahead of Item 8 (**Passed by Consensus**).

3. **APPROVAL OF MEETING MINUTES:**

**MOTION #2:** Approve the 9/2/2010 with Page 3, Item 7.B.3.b., Bullet 4 changed from "LAGLC now allots..." to "APLA now allots..."; 11/4/2010; 12/2/2010; and 1/6/2011 Standards of Care Committee meeting minutes (**Passed by Consensus**).

4. **PUBLIC COMMENT, NON-AGENDIZED:** There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED:** There were no comments.

6. **PUBLIC/COMMISSION COMMENT FOLLOW-UP:**

- Mr. Vincent-Jones noted he was not at the 1/6/2011 meeting, where his proposal to collapse standards for ADAP/ADAP Enrollment and Local Pharmacy Program/Drug Reimbursement (LPP/DR). SOC chose not to do a Pharmacy Assistance Standards of Care due to State ADAP regulations, but he felt discussion had not been properly contextualized.
- The Commission already has standards for both services. They are consistent with ADAP regulations and have the same goal of ensuring access to medications, and was simply intended as a mechanism to reduce the overall number of standards. Consolidating various standards will help promote the Commission's standards to other systems of care, as 30 separate standards can be intimidating.

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- Other consolidations will likely be proposed in future, but this is a good first choice as they reflect a continuum of meeting medication needs. There are funding and formulary differences, but those are not addressed in the standards.
- LPP/DR was developed in response to a HRSA requirement to track expenditures. It is now a Medical Outpatient line item for local drugs, e.g., non-formulary medications.
- Mr. Vincent-Jones noted standardizing funding and services is a separate issue, but integrating like standards can help. Mr. Vega-Matos noted clinic enrollment processes vary with capacity and systems, but standardized screening and access would also help.
- ➲ Phil Meyer will draft a consolidated ADAP/ADAP Enrollment and LPP/DR Standards of Care for SOC review.

### 7. CO-CHAIRS' REPORT:

- A. **Co-Chair Nominations:** Ms. O'Malley nominated Ms. Palmeros and Dr. Younai. Nominations will remain open until elections at the April meeting.
- B. **Committee Work Plan Review:** Mr. Vincent-Jones will develop a draft with the SOC Co-Chairs for April meeting review.

### 8. STANDARDS OF CARE:

#### A. Residential Care and Housing Services:

- ➲ Ms. Pinney will seek to complete the consolidated draft by the April meeting. It has been delayed by more organization, redundancy and consistency issues than anticipated.

#### B. Case Management, Housing:

Mr. Vega-Matos will send comments Commission staff regarding how Housing Case Managers should screen for certain issues. They are not trained to do a full assessment, which is the purview of the Psychosocial Case Manager.

#### C. Medical Care Coordination (MCC):

##### 1) *OAPP Recommendations Follow-up:*

- Mr. Vega-Matos presented a matrix of the Commission's Standards of Care (SOC) versus the OAPP MCC Model, which reflects discussions among OAPP, Transitional Advisory Group (TAG) and HRSA Consultant Donna Yutzy. Mr. Vincent-Jones noted prior Committee discussions. Ms. Yutzy felt inconsistency might require some SOC changes. If the OAPP requirements are more than reflected in the standard, then the standard can either be raised to that level or left as is, since the administrative agency is allowed to impose more requirements than called for in the standards.
- SOC and OAPP model goals are consistent, but the latter emphasizes: patient-centered medical home, eliminating service duplication, and standardizing assessment and acuity for medical and non-medical case management.
- Dr. Younai said goals and objectives should not be blurred as goals are overarching principles while objectives must be measurable. She supported OAPP model goals and felt they could simply be inserted at the start of sections.
- OAPP told the TAG it was critical for medical and non-medical case management to be co-located for the medical home concept to work. Primary care providers could provide it themselves or have another agency provide it within the clinic. In the latter scenario, there must be an agreement that spells out certain issues, e.g., access to medical charts.
- Dr. Younai noted the SOC did not require co-location, but presented it as one option for providing the service. Mr. Vincent-Jones said the question when the standards were being developed was whether one of minimum expectation. The higher expectation of co-location was discussed and most supported it. It was decided not to require it due to the logistical challenges it could present to agencies. Since OAPP is now requiring co-location, the standard could be adjusted accordingly.
- Dr. Younai felt standards should not be so specific to current services that they cannot adapt to future changes. She also felt it disrespectful to the process to make changes to fundamental standards provisions that had been developed by Expert Review Panels (ERPs) in Committee.
- Mr. Vega-Matos noted the medical home approach is embedded in Health Care Reform (HCR) law. OAPP has identified key components. Co-location is one such component, with flexibility provided for implementation.
- OAPP has developed some key performance indicators. Medical care indicators focus on treatment adherence, engagement in care and education such as Prevention for Positives. Non-medical indicators include focus on assessments with linked referrals for benefits specialty, mental health, substance abuse and housing.

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- There are now approximately 15,000 patient in Ryan White-funded medical clinics. It is not feasible to do full assessments of all and many are already self-managed. OAPP is developing a 14-question screening tool to be administered by clinic staff to new clients, and annually thereafter, or earlier should something in a regular medical visit trigger it.
- OAPP chose to develop its own screening tool after reviewing others available. Tools developed in various jurisdictions lacked validated scales and the desired breadth. Validated tools, such as for mental health, were 20 pages long.
- OAPP will pilot and validate the tool to ensure a full assessment is appropriately triggered when a client answers "yes" to any question. There is an acuity tool that identifies whether a client is high, moderate, low or self-managed acuity level.
- OAPP is identifying who needs MCC services. The SOC identifies the target population as everyone in or entering the Ryan White system. Mr. Vega-Matos felt the difference between that and the model is a semantic one that has confused some to think that all will have a full assessment and/or access to nurse or social worker all the time, which would be cost-prohibitive.
- The model will evaluate everyone. The self-managed are part of the MCC population and are attached to a medical home, but remain self-managed.
- Based on the Commission's fiscal tool and Casewatch, about 4,000 individuals will need MCC. OAPP wants to ensure that everyone in the system is screened and then accesses MCC if needed.
- Populations targeted for outreach are: PWH never in medical care regardless of diagnosis date; PWH who have not accessed medical care for at least six months; PWH in medical care, but with difficulties adhering to treatment; and PWH adherent to medical care, but with poor health outcomes.
- Expectation of outreach is a key service component, but "outreach" has varying goals, e.g., ensuring people are engaged and accessing service, retaining people in care, or finding and bringing new people into care. Outreach will focus on the model's target populations. Mr. Vega-Matos suggested future discussion on Testing and Linkage to Care Plus (TLC+) and re-targeting Early Intervention Services (EIS) to current needs. Outreach does not use nurses or social workers to identify clients, as some thought.
- Mr. Vincent-Jones noted that there is a separate Outreach standard and outreach components in other services. The Priorities and Planning (P&P) Committee has said it will fund Outreach in FY 2012. The standard allows funding for a separate category or as supplemental funds for other service categories. "Outreach" is defined in several ways, but also includes annual check-in with self-managed clients.
- He noted using the definition in the standard is important to ensure consistency. He added the definition ensures clients with private medical care can also be tracked with an annual check-in.
- OAPP has attempted to estimate those outside the RW system who may need MCC. 200 have neither public nor private insurance. They compared those in medical outpatient and those accessing non-medical case management or other services. They then checked if they had public or private services and where those were accessed. Providers are being asked to medically track clients accessing private care, which may become more when HCR moves many outside RW.
- Mr. Vincent-Jones said Commission cost projections indicated 17,000 in the RW system with 14,000 accessing RW-funded medical care. The Commission estimated 1,500 accessed other medical care systems with 2,500 receiving none. Mr. Vega-Matos said Dr. Green is reviewing predictions in light of the 1115 Waiver.
- He reported OAPP is still working on case loads and FTEs as providers differ on acuity mixes. Those areas will be addressed after the other components, such as the acuity tool, are developed first.
- OAPP is still developing centralized intake and screening via computer. Mr. Vincent-Jones noted concerns that OAPP had identified earlier that benefits specialists would conduct intake whereas the Commission had intended Benefits Specialty as a secondary level of assistance for more complex needs. Mr. Vega-Matos said OAPP has shifted that responsibility to MCC, but had read the Benefits Specialty standard as more comprehensive since it discusses initial intake. Mr. Vincent-Jones agreed to review the standards and propose any modifications to clarify its intent.
- Mr. Vega-Matos said HCR underscores the importance of maximizing resources. All clients entering the RW system must have comprehensive intake and screening to evaluate their needs and advocate for them to access needed services. Mr. Vincent-Jones said Ms. Cross has said any case worker should be able to minimally enroll a client into

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other benefits systems. A client is referred to a benefits specialist when it is more complex or complicated than can be expected of the routine case worker.

- Mr. Vega-Matos said there are now 12 Benefits Specialty contracts, but they are not linked to the screening and enrollment process. Eventually HCR requirements will link them.
- He noted that the MCC standard does not specify case conference frequency. The OAPP model links frequency to acuity level and an integrated care plan. Minimally, the nurse and social worker should participate on the same phone call. Mr. Vincent-Jones responded that the Committee purposefully left that question unanswered because any minimum expectation would be arbitrary until implementation experience could help frame it. He added, though, that estimates of case conferencing frequency were included in the financial modeling in order to generate cost estimates.
- Mr. Vega-Matos felt that, overall, OAPP is within the standards framework with most differences semantic. Mr. Vincent-Jones noted the Commission mostly used terminology from existing models, such as Kaiser's, e.g., a client has a medical home regardless of frequency. He added that OAPP's implementation plans seem to reconcile closely with minimum expectations from the standard and OAPP's authority to impose additional conditions.
- Mr. Vega-Matos noted the Medi-Cal 1115 Waiver pays for care coordination. OAPP will require MCC providers to be Medi-Cal certified. Mr. Vincent-Jones added that supports adoption of Commission standards by other plans and the current Ryan White requirement that medical outpatient providers are Medi-Cal-certified.
- Mr. Vega-Matos noted MCC is rolling out in SPA 1 while four other providers have components in place and asked to work with OAPP as they further develop their own models. Those services are being called "Blended Case Management" to avoid confusion. Participants are: City of Pasadena, St. Mary's Medical Center in Long Beach, Northeast Valley Healthcare Corporation, and AIDS Healthcare Foundation.
- OAPP has also held its first meeting with 5P21 to initiate a medical home project funded by a CHRP grant. There are logistic issues with developing MCC in County facilities, e.g., hiring restrictions. Creative solutions may include partnerships with non-County providers. Mr. Vincent-Jones noted the Commission very actively advocated for CHRP to improve its medical home model and expand funding availability to LA County in its RFP through various conversations with CHRP staff and by providing them with the Commission's MCC materials.
- Some form of MCC is now being tested at County and non-County providers, larger and smaller providers, rural areas and urban ones with a high acuity populations. Mr. Vincent-Jones asked how OAPP would maintain a level RFP playing field given some providers are already going to be working with OAPP on implementation. Mr. Vega-Matos said services often start with a few providers. The four blended providers approached OAPP—rather than OAPP approaching them—and already had contracts in place for nurse and psychosocial case management.
- Mr. Guitron asked about medical case management training. Mr. Vega-Matos said there has been work on standardizing assessment tools and expectations. Dr. Jennifer Sayles, Medical Director, is planning the training.
  - ⌚ Incorporate OAPP Model goals at the start of pertinent sections.
  - ⌚ Mr. Vega-Matos will check on how Hepatitis C co-infected patients are addressed in the model.
  - ⌚ Staff will review Benefits Specialty Standards of Care to ensure clarity of intent.
  - ⌚ Mr. Vega-Matos will send Mr. Vincent-Jones the OAPP scope of work for Benefits Specialty.
  - ⌚ Staff will add a Commission response column to the matrix and bring it back to the April meeting.

**D. Health Insurance Premiums/Cost-Sharing (HIP/C-S):** This item was postponed.

**E. Early Intervention Services (EIS):** This item was postponed.

**F. FY 2011 RFP/Contracting Schedule:** This item was postponed.

## **9. PRIORITY- AND ALLOCATION-SETTING (P-AND-A) RECOMMENDATIONS:**

**A. Seasonality of Mental Health (MH), Psychotherapy:**

- Mr. Vega-Matos said he started investigating whether continuity of care was compromised when interns moved on to other placements, consistent with one of the P-and-A directives from last year. He found during providers did not always understand regulations governing different types of MH interns, e.g., differing requirements, supervision levels, hours and how many can be supervised at the same time.

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- OAPP has looked into both areas and provided technical assistance to the providers that needed it. Monitoring during the last few months has indicated improvement in transition from one intern to the next. OAPP has also been working closely with two providers on some supervision concerns.
- ➡ Mr. Vega-Matos is working on a report that he will present at the April SOC meeting.

### **B. Substance Abuse (SA) Consistency with HRSA:**

- Mr. Vega-Matos reported that OAPP was addressing both SOC consistency with the HRSA service category description and the broader issue of a County evidence-based and best practices-driven SA treatment network.
- Substance Abuse and Prevention Control (SAPC) was also revamping its SA portfolio, but has put their effort on hold pending review of the overall SA network in light of Health Care Reform (HCR).
- A large portion of SA treatment is based solely on social models. OAPP is working with a consultant to review how to incorporate mental health components, biomedical markers and addiction medicine. It is also reviewing the SA continuum, including after-care, outpatient treatment, residential care and services for special populations, such as transgenders.
- Dr. Younai has heard various approaches from her SA colleagues and questioned how to identify a cohesive approach. Mr. Vega-Matos said Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institutes of Drug Abuse (NIDA) research is under review, including best practices on co-occurring disorders pertinent to many Ryan White clients.
- He noted significant SA client recycling. One school of thought believes in striving to avoid relapse while another considers it part of the recovery process. OAPP is reviewing research, but believes lack of key components plays a role.
- Mr. Vega-Matos noted he once ran SA treatment programs that included psychiatrists, nurses, clinical social workers, tests and biomarkers, and worked closely with several co-occurring disorders researchers. There is some contention about addiction medicine, but OAPP is focusing on medications to help cravings or control withdrawal symptoms.
- Mr. Vincent-Jones noted the consistency question was brought to the Priorities and Planning (P&P) Committee. He felt the existing SA standards should be consistent with HRSA definitions—since those were reviewed prior to developing the standards—unless HRSA's definition have changed. If OAPP feels there is some inconsistency, then that should be addressed promptly. Otherwise, revisions can be considered once OAPP completes its research and the Commission performs its update.
- ➡ Mr. Vega-Matos will review SA consistency with HRSA and report back.
- ➡ Mr. Vincent-Jones suggested consolidating the SA Treatment and SA Residential Standards of Care once OAPP has completed its recommendations. Mr. Vega-Matos anticipated a report sometime during the summer of 2011.

### **C. Cost Impact and Standards Feasibility:**

- Mr. Vincent-Jones noted that the discussion about studying cost impact and standards feasibility at the prior SOC meeting seemed to imply confusion with rate studies. While the Commission could conduct rate studies, they have traditionally been OAPP's purview, as indicated in Commission policy. P&P asked for SOC study to answer two questions that have been raised repeatedly: 1) Are standards, as written, cost-feasible? and 2) Should the Commission consider costs when creating its standards?
- A mechanism to answer these questions, he proposed, is much simpler and can be done much more quickly. It need not take a year per standard, as was discussed at the prior Committee meeting and which would be more akin to a formal rate study. He also felt it was good timing to consider and respond to these questions, as outside providers will ask them when the Commission's promotes the use of their standards under health care reform.
- All standards include inserts detailing service components. The current cost in existing services can be averaged for a figure than can contribute to an overall service cost and assess if the way the standards have been constructed is economically feasible. Contrary to the Committee decision to study one standard a year, he felt the entire feasibility study of all of the standards could be completed over the course of several months.
- He agreed that MH, Psychiatry and Oral Health Care are good first standards are good to start with given that costs can be attributed to their more defined procedures and/or medications more easily. OAPP data on total patient numbers, visits and procedures can be used to verify if current spending does not align with projected costs, but will not be exact as OAPP does not reimburse on a fee-for-service based and most agencies also use other resources to pay for services.
- In spite of these questions being raised repeatedly, the standards were developed based on current practices, and are consistent with Public Health Service (PHS) guidelines and services already outlined in contracts, so he expected the study to verify that the standards are economically-feasible.

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- ⌚ Review feasibility based on the above discussion. The Cost Impact and Standards Feasibility Subcommittee will identify sources, e.g., laboratory codes, for each component. Ms. O'Malley joined the Subcommittee.
- ⌚ Mr. Vincent-Jones will draft a model detailing how and what information needs to be collected based on a single standard to the next Subcommittee meeting.
- ⌚ Change meeting times as follows: SOC Committee meeting, 9:30 to 11:30 am; Subcommittee, 11:30 am to 1:00 pm.

**10. GRIEVANCE POLICY AND PROCEDURES:** This item was postponed.

**11. QUALITY MANAGEMENT REVIEW:** This item was postponed.

**12. SPECIAL POPULATION GUIDELINES:** This item was postponed.

**13. EVALUATION OF SERVICE EFFECTIVENESS (ESE):** This item was postponed.

**14. CONTINUUM OF CARE:** This item was postponed.

**15. AETC REPORT:** There was no report.

**16. NEXT STEPS:** There was no additional discussion.

**17. ANNOUNCEMENTS:** There were no announcements.

**18. ADJOURNMENT:** The meeting adjourned at 12:25 pm.